EVALUATION OF THE UNICEF PMTCT / PAEDIATRIC HIV CARE AND TREATMENT PROGRAMME
Evaluation of the UNICEF PMTCT/Paediatric HIV Care and Treatment Programme

Summary report

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INTRODUCTION

In 2005, programmes for HIV prevention, care and treatment among children were only starting up in most low- and middle-income countries (LMICs) and coverage levels were still very low. In 2005, only 9 per cent of pregnant women living with HIV received antiretroviral (ARV) medications for prevention of mother-to-child transmission (PMTCT), resulting in more than 600,000 new infections among children. Access to ARV treatment (ART) for people living with HIV remained low, with only 1.3 million people receiving ART and few of them children.²

Commitments to address these gaps mounted in the period 2005–2011 (see Figure 1). In 2006, the United Nations General Assembly High-Level Meeting on AIDS resulted in commitments to mobilize additional resources and expand and accelerate the HIV/AIDS response towards the 2015 targets.³ The 2011 Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive (hereafter referred to as ‘the Global Plan’) provided global targets for the elimination of mother-to-child transmission of HIV (eMTCT) by 2015 and called for a concerted country-driven effort to guide action towards these targets. The Global Plan covered all LMICs but called for exceptional efforts in the 22 countries with the highest estimated numbers of pregnant women living with HIV.

The subsequent scale-up of ARV-based prevention and treatment programmes among children in LMICs was impressive. In the 21 Global Plan priority countries in sub-Saharan Africa, coverage of ARV medications among pregnant women living with HIV increased from 36 per cent in 2009 to 80 per cent in 2015, and new HIV infections among children declined by 60 per cent, from 270,000 in 2009 to 110,000 in 2015.⁴ By 2016, four countries (Armenia, Belarus, Cuba and Thailand) were certified as having achieved eMTCT.⁵ Global coverage of ART among people of all ages reached 46 per cent (17 million people) at the end of 2015,⁶ with Eastern and Southern Africa experiencing the largest gains.⁷

The scale-up and improvement of PMTCT services reduced the annual number of new infections among children globally by 56 per cent between 2010 and 2015 and by 70 per cent between 2000 and 2015.⁸ Since 1995, an estimated 1.6 million new HIV infections among children have been averted thanks to the provision of ARV medicines to pregnant or breastfeeding women living with HIV (see Figure 2).⁹

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² Ibid.
⁷ Ibid.
⁹ Ibid.
Progress towards global targets has been uneven, however, and significant challenges remain. Coverage of PMTCT interventions has not increased as planned in all countries, children’s access to treatment remains low in many places and HIV risk remains unacceptably high among young women of reproductive age. The global burden of infection has remained high, with 36.7 million people of all ages living with HIV.11 Many women, including women living with HIV, do not have access to the family planning services they need and as a result, HIV exposure of infants remains high.
THE UNICEF RESPONSE

Since 2005, UNICEF has taken a leading role in helping LMICs scale up programmes to prevent new HIV infections among children. This has included supporting HIV care and treatment for children living with HIV and their families, preventing and treating new infections among adolescents, providing protection, care and support to families affected by HIV and extending HIV services to children and families during emergencies.

Eliminating mother-to-child transmission of HIV and providing care and treatment to people living with HIV remain global priorities on the post-2015 agenda and are central to the commitment to end AIDS by 2030. UNICEF and its partners are therefore contributing to the Joint United Nations Programme on HIV/AIDS (UNAIDS) Strategy (2016–2021) to Fast-Track the response to end AIDS by 2030, as well as A Promise Renewed, the call to action to end preventable child and maternal deaths.

UNICEF has commissioned a corporate evaluation of its PMTCT/paediatric HIV care and treatment programme to reflect on its contribution over the period 2005–2015 and inform its positioning going forward. This report presents a summary of the strategic context, methodology, key findings, conclusions and recommendations of that evaluation.
EVALUATION SCOPE AND METHODOLOGY
The evaluation aims to support accountability and learning in regards to UNICEF’s efforts to support the scale up of PMTCT and paediatric HIV care and treatment programmes. The findings and recommendations will be used to guide UNICEF’s sectoral and cross-cutting implementation strategies for achieving the HIV outcomes specified in the Strategic Plan 2014–2017; to steer UNICEF’s future work within the 2030 Agenda for Sustainable Development; and to inform UNICEF’s thinking with respect to the positioning of HIV/AIDS in its new Strategic Plan 2018–2021 and the management of the UNICEF HIV portfolio going forward.

THE EVALUATION HAS TWO KEY OBJECTIVES:

1. **To contribute to improving the organization’s accountability** for its performance by defining and documenting key achievements as well as missed opportunities in UNICEF’s engagement with partners and countries in support of improved PMTCT and paediatric HIV care and treatment outcomes between 2005 and 2015;

2. **To generate evidence and learning** to enhance the understanding of the organization and other stakeholders on how UNICEF’s strategies and programmes related to PMTCT and paediatric HIV care and treatment have evolved, what has worked, what has not worked and why and to make recommendations for UNICEF’s future engagement in PMTCT and paediatric HIV care and treatment.
Four aspects of UNICEF’s PMTCT and paediatric HIV care and treatment programming efforts over the period 2005–2015 were examined in the evaluation:

1. Leadership, advocacy, coordination and partnerships
2. Resource mobilization
3. Strategic information, knowledge generation and dissemination
4. Key aspects of UNICEF’s organization

The evaluation was also directed to address three cross-cutting issues – **gender**, **human/child rights** and **equity** – and to examine how the response to PMTCT and paediatric HIV has played out in **humanitarian situations**.

This evaluation is theory-based, which means it is centred on the use of a theory of change to explain and document assumptions made along the way and the processes and causal pathways by which the programme is expected to have led to its intended results. The theory of change for this evaluation formed the basis for the development of the key evaluation questions (see Figure 3).
The rights of every child, especially the most disadvantaged, to be protected from HIV infection and live free from AIDS are realized

Improved and equitable use of proven HIV prevention and treatment interventions by children, adolescents, pregnant women and mothers

HIV policies and programmes are resourced and implemented in a gender-sensitive, equitable and human-rights based manner (including in humanitarian situations)

Strategies, policies and implementation plans are aligned and coherent across partners at global, regional and country levels

Levels of political commitment and capacity of governments and other global, regional and national stakeholders to plan for and support scale-up of HIV services for children are increased

Resource needs for PMTCT and paediatric HIV care and treatment are met in a predictable and sustainable manner

Mechanisms to ensure accountability for provision and scale-up of PMTCT and paediatric HIV care and treatment are strengthened at all levels

Strategies, policies and approaches to implementation are informed by evidence on what does and does not work and why in relation to PMTCT and paediatric HIV care and treatment

Evoking global context related to PMTCT and paediatric HIV (including changing epidemiology, policies, treatment guidelines and funding environment)

SD 1 Coordinate programme design, planning and implementation among partners at all levels

SD 2 Broker partnerships at all levels, including among private sector, civil society and multi-sector stakeholders, and encourage South-South as well as triangular cooperation among partners

SD 3 Ensure that HIV services for children receive adequate priority in global, regional and national decision-making

SD 4 Support key stakeholders at all levels to plan, resource and implement HIV services for children

LEADERSHIP, ADVOCACY, COORDINATION AND PARTNERSHIPS

SD 5 Initiate, support and coordinate movements, campaigns and investment plans to mobilize financial resources

SD 6 Engage with donors, governments and country stakeholders to leverage additional global and domestic resources, and support countries to access external resources

RESOURCE MOBILIZATION

SD 7 Generate, collate and disseminate strategic information and knowledge

SD 8 Provide support for governments and country partners to generate and collate strategic information and knowledge

SD 9 Support countries to interpret and translate evidence into sound policies, strategies and programme implementation

STRATEGIC INFORMATION, KNOWLEDGE GENERATION AND DISSEMINATION

SD 10 Work to ensure that effective interventions are adequately integrated within humanitarian responses

SD 11 Advocate for and support gender-equitable policies, budgeting and resource allocations, and gender-sensitive approaches to HIV programming and monitoring

SD 12 Ensure that human rights and child rights are protected, promoted and fulfilled in HIV policies and programmes and build related accountability mechanisms

SD 13 Promote an equity focus in HIV services for children, and build related accountability mechanisms

CROSS-CUTTING ISSUES

SD 14 UNICEF as an organization responds to changes in the external environment and leverages its comparative advantage in PMTCT and paediatric HIV care and treatment
DATA COLLECTION METHODS:

- **Structured document review**: UNICEF strategic planning documents and progress reports; internal survey of UNICEF country office staff; policy, guidance and advocacy documents; financial data; strategic information and knowledge products; UNICEF staffing and reporting information.

- **Key informant interviews / group discussions**: Conducted with a total of 243 people at global, regional and national levels from UNICEF, UNAIDS, the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and other international non-governmental organizations.

- **Online survey**: An e-survey was conducted to incorporate the views of a wide range of respondents at the country level, including government actors, development partners and staff from organizations working on PMTCT/paediatric HIV care and treatment.

- **Light touch country case studies**: Evidence was gathered on three lower prevalence countries not prioritized within the Global Plan – Cambodia, Haiti and Ukraine – through document review and remote interviews.

- **In-depth country case studies**: Field visits were conducted in four high-burden countries prioritized in the Global Plan – Cameroon, India, South Africa and Zimbabwe – to record how UNICEF delivered its programme on HIV in children at the country level.
DATA ANALYSIS METHODS:

Document analysis:
Extensive review of available documentation informed the various components of the analysis.

Interview and group discussion analysis:
Interviews were coded thematically based on a coding structure linked to the evaluation questions.

Survey data analysis:
Qualitative data was analysed by theme and quantitative data was analysed through the creation of summary statistics.

Recording and analysis of timelines:
Timelines were constructed to describe the evolution of the programme since 2005 and explore ways that UNICEF has responded to and influenced the evolving context.

Trend analysis:
Quantitative data such as financial resources were analysed for both UNICEF and the relevant programme areas.

Cross-case study analysis:
Analyses of each thematic area were undertaken to highlight common themes and issues and identify contrasts and similarities.

The evaluation methodology was subject to some limitations. These included strong reliance on qualitative data and the associated risk of recall bias; the initial focus on countries prioritized in the Global Plan; risk of selection bias in the online survey; limitations in the financial data due to a change in the accounting policy; lack of evidence on the UNICEF response to PMTCT and paediatric HIV in humanitarian situations; and the focus on assessing UNICEF’s contributions to programme responses rather than outcomes and impact. Most of these limitations were identified during the inception phase and addressed through mitigating measures.
FINDINGS
THEMATIC LEADERSHIP, ADVOCACY,
COORDINATION AND PARTNERSHIPS

UNICEF and partners have played a critical role in scaling up HIV prevention, care and treatment programmes for children through targeted advocacy, the organization’s convening role at the global, regional and country levels, and substantive financial and technical support to country level partners. The scale up of paediatric HIV treatment programmes continues to lag behind, however, and large gaps in paediatric ART coverage persist in most settings.

The 2011 Global Plan is widely viewed as a game changer, having attracted and consolidated financial and technical resources around a set of ambitious targets for reducing new HIV infections in children in priority countries. UNICEF’s contributions to the Global Plan have been primarily programmatic and technical, however, with little high-level political involvement. Nonetheless, country case studies illustrate that UNICEF and its partners moved quickly to support the process of mobilizing national stakeholders around the 2015 eMTCT targets and translating national commitments into action.

UNICEF has forged strong strategic alliances with a range of partners, including as part of the Inter-Agency Task Team and through other mechanisms aimed at addressing programme scale-up. In case study countries, UNICEF is widely recognized as a lead player for issues related to HIV in children, having helped to align strategies, policies and implementation plans across partners and ensure their coherence with national priorities.

The organization has also made a strong push to integrate HIV services within the maternal, newborn and child health platform, in line with ‘Double Dividend’ principles. Vertical approaches to HIV programming at the country level have, however, tended to dampen UNICEF’s efforts to reinforce linkages between health and HIV at planning and management levels and more widely across programmes and sectors. More work is also required to strengthen community systems.

RESOURCE MOBILIZATION

UNICEF has strong internal processes and institutional capacity for resource mobilization and the organization’s fundraising efforts are well regarded. The organization has overall played a valuable role in supporting countries to access external resources, particularly from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). UNICEF has also contributed to an increase in domestic financial resources in some countries, and has sought to identify and promote programme efficiencies to reduce resource requirements.

Despite increasing revenues and rising global financing for HIV/AIDS, UNICEF’s other resources for HIV/AIDS have declined since 2008. The organization’s expenditure on HIV/AIDS has also declined over time, accounting for just 2 per cent of total programme expenditure in 2015 (down from 8 per cent in 2005). Evidence is mixed on the extent to which UNICEF’s country office resource needs have been met.

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12 The trend line is based on total resources for HIV/AIDS between 2005 and 2015. Source: analysis of internal UNICEF data.
Fundraising for PMTCT and paediatric HIV has been a key challenge in many countries and has become more difficult in recent years. Possible reasons for this include: a sense within the global community that the job is done following the reduction in the number of new HIV infections; a shift in donor priorities away from HIV/AIDS following the progress made towards Millennium Development Goal 6; and the leadership of the Global Fund and the United States President’s Emergency Plan for AIDS Relief (PEPFAR) in this area, which gives the perception of limited requirements for other donors/agencies.

The high proportion of UNICEF’s resource base that is tightly earmarked has led to an increase in the transaction costs associated with the preparation, implementation, monitoring, enforcement and reporting of donor agreements, and restricted UNICEF’s ability to flexibly programme resources. There is also a concern that the share of earmarked resources will increase even further in the future as a result of cuts to Unified Budget, Results and Accountability Framework funding, and that unless flexible resources are used in its place, this may distort UNICEF’s future decision-making processes for programming.

Although financial resources for PMTCT and paediatric HIV care and treatment have increased over time, UNICEF has not played a prominent role in leveraging other donor resources at the global level and there have been significant resource gaps in some countries for the implementation of national HIV programmes.

Figure 5: UNICEF expenditure on HIV/AIDS, 2005-2015

Figure 6: UNICEF expenditure on PMTCT and care and treatment of children affected by HIV/AIDS

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13 UNICEF HIV annual results reports from 2005 to 2014 and analysis of internal UNICEF data.

14 Based on analysis of internal UNICEF data.

15 UNICEF’s internal reporting follows the structure of its organizational strategic plans, and as such, the data reflects a change in the coding of expenditures between the Medium-Term Strategic Plan 2006-2013 and the Strategic Plan 2014-2017. More specifically, for 2012 and 2013, the figures for PMTCT and care and treatment of children affected by HIV/AIDS present expenditure to reduce the number of paediatric HIV infections; increase the proportion of HIV-positive women receiving ARVs; and increase the proportion of children receiving treatment for HIV/AIDS. For 2014 and 2015, the figures for PMTCT and care and treatment of children affected by HIV/AIDS present expenditure for two programme areas: a) PMTCT and infant male circumcision; and b) care and treatment of children affected by HIV/AIDS.

16 There are difficulties in interpreting the data for PMTCT and care and treatment of children affected by HIV/AIDS, particularly as the use of funding for the ‘HIV general’ category, accounting for 42 per cent of total HIV expenditure, is unclear and it has not been possible to assess whether this has benefited PMTCT and paediatric HIV. As such, the data should be interpreted with caution.
UNICEF has made considerable investments in knowledge building to support advocacy, resource mobilization, priority-setting, programming, and monitoring and evaluation of HIV prevention and treatment among children. Working with partners, UNICEF has generated, analysed and disseminated strategic information on the HIV epidemic in children and on progress towards programme targets, both at the country and the global levels. UNICEF is especially recognized for its push for age- and sex-disaggregation of data. These activities have reinforced accountability processes at all levels. UNICEF’s work on strategic information has had limited visibility, however, despite the organization’s considerable investments.

The organization has also championed data-driven approaches to improving programme performance. For example, in South Africa, UNICEF provided guidance on processes for analysing programme performance and identifying bottlenecks in implementing the eMTCT framework, which were introduced across all provinces and districts in 2011. UNICEF has also pioneered innovative data management approaches to improve service delivery for children affected by HIV, including approaches that can be used in low-resource settings.

Through the collective work of partners such as UNICEF, WHO, UNAIDS and the Centers for Disease Control and Prevention, the number of countries reporting on PMTCT coverage increased from 7 in 2015 to 134 in 2014.

82 and 81% of e-survey respondents agreed that UNICEF had played an important role in the generation and dissemination of data and knowledge, respectively, while 76% agreed that UNICEF’s work on data and knowledge had contributed to progress in scaling up services in their country.

In Cambodia, UNICEF supported the development of the Exposed Infant Database, which is improving the identification and follow up of HIV-exposed infants.
UNICEF ORGANIZATIONAL STRUCTURE

UNICEF has deployed diverse approaches to addressing its corporate priority on HIV/AIDS at different levels of the organization. Some regional strategic priority documents and many country programme documents clearly single out HIV/AIDS as a major priority while others have incorporated HIV within other overarching priorities. UNICEF offices have diverse staff structures and have tailored their engagement in the children and HIV response accordingly. This flexibility and responsiveness to country needs and priorities is highly valued by national stakeholders, given the diversity of settings and the rapid pace of development of the response to HIV in children over the last several years.

Over time, UNICEF has struggled to adapt to dwindling financial and human resources for its HIV/AIDS work, however. Dedicated PMTCT and paediatric HIV care and treatment staff numbers decreased in some case study country offices over the evaluation period (notably in Cameroon, India, Haiti and Ukraine), including international staff posts, as financial resources for HIV declined, resulting in fewer staff, at lower levels. Examples of shared HIV accountabilities across programmes are rare. In such circumstances, there is some evidence that UNICEF’s ability to meet demands for HIV/AIDS results has been stretched.

71% of internal and 75% of external e-survey respondents agreed or strongly agreed that UNICEF has responded appropriately to developments in PMTCT and paediatric HIV over time and made the necessary internal adjustments.

THE EVOLUTION OF THE ORGANIZATIONAL STRUCTURE IN UNICEF ZIMBABWE

Multiple organizational shifts have taken place in UNICEF Zimbabwe as the HIV programme has evolved. In 2005, a small team of people carried out HIV functions from their location in different sections across the office. As their numbers grew, they formed a separate HIV team between 2007 and 2009. This team was then situated within the health and nutrition section, with its senior member serving as a separate HIV advisor (working on higher level policy issues) reporting directly to the Deputy Representative. This stimulated the integration of HIV and health functions but led to reduced visibility and less engagement with some programme areas outside of health, such as child protection. A standalone HIV section was recreated in 2015 to increase focus and visibility for eMTCT.

CROSS-CUTTING ISSUES

Gender

UNICEF’s focus on women and children is evident and the organization has vocally advocated for the availability of sex-disaggregated data to inform programming. While stakeholders recognized UNICEF’s innate focus on women and children, they also felt that the organization is not making “enough noise” on the issue of gender, as one regional office respondent said. There is also scope for broader gender issues to be more fully integrated within the HIV response – moving beyond a focus on women and children to consider complex gender dynamics more comprehensively.

In India, UNICEF vocally pushed for age, caste and gender-disaggregated data.
Equity

Both internal and external respondents generally (though not universally) recognized UNICEF’s mandate and focus on equity in relation to PMTCT and paediatric HIV. Among the UNICEF respondents interviewed, there was clear consensus that equity was a strong part of the programme. The use of bottleneck analysis tools (including through the Monitoring Results for Equity System) is recognized as a critical contribution by UNICEF to the scale-up of national responses. However, in Cameroon, Haiti, India, South Africa and Zimbabwe, there was evidence that more could be done to move beyond a geographical focus and target the most vulnerable and hard-to-reach.

More than 70% of survey respondents felt that UNICEF had either a strong or moderate focus on equity as part of its approach to PMTCT and paediatric HIV care and treatment at the country level.

“Equity is really part of UNICEF’s DNA... making sure that no one is left behind.”
– A UNICEF country office respondent

“We have a composite index of the 184 high priority, poorly performing districts and UNICEF supports us in 75% of these.”
– A government official in India

Human rights

Although UNICEF has a clear mandate on human rights, this is not always prominent externally. There was some sense that UNICEF could be more vocal on rights-based issues, particularly in the case studies in Zimbabwe and South Africa and among some global development partner respondents. Respondents also felt that UNICEF should better leverage existing opportunities for maximizing programme linkages and more actively promote human rights within the broader HIV response. Many respondents noted that UNICEF is well positioned to take up this mantle and support a holistic approach, given its mandate on rights and that it works across a variety of programme areas.

“I would probably say that for human and child rights, perhaps the voice has been stronger and louder from UNICEF.”
– A global development partner

“People look to UNICEF for ‘a human rights-based approach’, but there is a sense that it’s a bit tired and it needs to be more progressive. For me personally, [UNICEF] has the opportunity to really claim the space around proper rights and protection around HIV and sexual and reproductive health for children and young people.”
– A global development partner

Humanitarian situations

UNICEF has advocated for and supported the inclusion of PMTCT/paediatric HIV care and treatment services in various emergency situations. The organization has also reflected on areas of improvement and contributed to guidance on integrating HIV services into humanitarian response. More could be done to consistently integrate PMTCT/paediatric HIV/AIDS concerns into UNICEF’s humanitarian response, however. Less than half of survey respondents believed that PMTCT and paediatric HIV care and treatment have been adequately integrated into humanitarian responses.17

“Definitely there is improvement to be sought. Most of the time, where there is an emergency, the eMTCT component is not prioritized.”
– UNICEF regional office staff member

During the 2014–2015 conflict in Ukraine, UNICEF played a critical role in the humanitarian response in non-government controlled areas in eastern Ukraine supporting the provision of HIV treatment to women, children and adults. Since 2015, UNICEF has ensured that 8,000 people living with HIV in eastern Ukraine (including 300 children and 600 pregnant women) were able to continue ART.

17 Forty-nine per cent agreed or strongly agreed that PMTCT and paediatric HIV care and treatment have been adequately integrated into humanitarian responses. Forty-six per cent felt that PMTCT and paediatric HIV care and treatment in humanitarian situations is a moderate or strong focus for UNICEF. Full breakdown of the responses is included in the full report, Annex I, Tables I.38 and I.42.
CONCLUSIONS AND RECOMMENDATIONS
CONCLUSION

UNICEF’s contributions to programme scale-up evolved over the evaluation period. The past five years have been the organization’s most productive in terms of expanding and improving HIV prevention programmes for children. Paediatric HIV treatment programmes have not been scaled up as efficiently, however.

Between 2005 and 2010, UNICEF invested in a broad range of activities focused on taking HIV prevention, care and treatment interventions to national scale and strengthening programme implementation. This contributed to steady, incremental increases in programme coverage globally and in many high-burden countries, though progress towards expected results remained insufficient. The Global Plan enabled UNICEF to focus its contributions between 2010 and 2015 on supporting national stakeholders to develop plans for reaching the 2015 eMTCT targets and effectively leverage available resources from national budgets, the Global Fund and PEPFAR. UNICEF also built on scientific advances and programmatic experience to promote critical policy changes at the country level, including the rapid adoption of Option B+ in 2011, which facilitated impressive gains towards increasing PMTCT coverage and reducing transmission rates in high-burden countries. However, although UNICEF has made important contributions to addressing technical and programmatic challenges related to the follow-up and diagnosis of HIV-exposed children and the care and treatment of young children living with HIV, large gaps in paediatric ART coverage persist in most settings.

UNICEF and partners have played a critical role in scaling up HIV prevention, care and treatment programmes for children through targeted advocacy, its convening role at the global, regional and country levels and substantive financial and technical support to country level partners in areas such as policy development, programme planning, implementation support and knowledge generation.

UNICEF has been a visible and prominent advocate for scaling up HIV prevention and treatment services for children, though this has been less on the political and more in the programmatic and technical arenas. The organization has forged strong strategic alliances with a range of key stakeholders and has devoted considerable resources to bolstering partner coordination arrangements within and outside of the United Nations system. UNICEF’s decentralized decision-making, country presence and expertise in child health and development issues have served as a strong foundation for supporting the national scale-up of PMTCT and paediatric HIV care and treatment in diverse country contexts. UNICEF has supported the expansion of programmes, strategy and policy development as well as data-informed priority-setting and implementation at all levels of health systems. Finally, UNICEF has worked with partners to pioneer innovative programme approaches to improve the reach and quality of HIV services for women and children.

HIV/AIDS has been a corporate priority throughout the evaluation period, though it has been operationalized in diverse ways at different levels in an effort to tailor approaches to specific contexts.

In recognition of the importance of regional and country contexts and of the idea that ’one size does not fit all’, UNICEF offices have employed diverse staff structures and tailored their engagement in the HIV response accordingly. Regional strategic priority documents and many country programme documents clearly identify HIV/AIDS as a priority, while others incorporate HIV within other overarching priorities (e.g. child survival and development). Stakeholders value this flexibility and responsiveness to country needs and priorities.

The rapid and substantial decline in UNICEF’s resources for HIV/AIDS since 2005 has put pressure on its PMTCT/paediatric HIV care and treatment work.

The decline in UNICEF’s HIV/AIDS expenditure over time has severely curtailed the organization’s ability to achieve results in many settings and limited the visibility of its HIV/AIDS work. In addition, a large proportion of UNICEF’s HIV/AIDS resources are tightly earmarked, leading to high transaction costs and restricted flexibility of use. The future cuts to Unified Budget, Results and Accountability Framework funding and expected challenges in accessing other HIV/AIDS funds will further inhibit UNICEF’s ability to contribute to this programme area in the future and may distort strategic approaches.
UNICEF is widely perceived as the organization that can support programme integration at all levels, from planning to service delivery. However, evidence of advances in this area remain limited.

UNICEF has made a significant effort to integrate HIV services within the maternal, newborn and child health platform in line with ‘Double Dividend’ principles. This integration effort has not yet been fully realized in all contexts, however, and there is little evidence of broader programme linkages. In some countries, UNICEF has struggled to manage vertical structures in which responsibilities for HIV and children are fragmented across various institutions and planning and budgeting processes are separate. Corporate policy and guidance has not translated into practice in such settings, with many missed opportunities for cross-sectoral collaboration. There is also a heavy reliance on health system solutions to increase programme reach and coverage within UNICEF and more broadly. Linkages must be developed at all levels, more widely across programmes and sectors and into the community. Part of the problem relates to UNICEF’s internal structures and operations, which tend to compartmentalize HIV work, with limited examples of cross-sectoral collaboration and shared accountabilities.

Progress towards preventing new infections among children has been unequal between and within countries and remains fundamentally challenged by issues related to gender, human rights and inequality across the wider social determinants of health. Although UNICEF has the potential to inform and drive the agenda around these issues, the organization is not currently making the most of its position.

While impressive gains have been made, progress in scaling up PMTCT and paediatric HIV care and treatment has been uneven across and within countries, demonstrating that equity challenges remain. Although UNICEF has effectively advocated for approaches that support the geographical prioritization of underserved areas, there is less evidence that these tools are being used to focus attention on the most vulnerable, marginalized and disadvantaged. Maintaining emphasis on these populations will become increasingly critical as coverage increases and in the face of pressure to maximize yield. UNICEF is seen as an organization that can keep equity issues on the agenda.

In regards to gender, although UNICEF is credited for its focus on women and children, its profile on broader gender issues in relation to the response is less evident. More gender-transformative approaches are required to address some of the key challenges in PMTCT, including how gender dynamics and power relations interact with the risks of contracting HIV and the ability to access care among women. There is an opportunity for UNICEF to position itself more integrally in regards to this agenda – for example, by building on its success in pioneering innovative approaches through exploring models for involving men.

Though much has been accomplished, many countries still face enormous challenges to achieving targets, and the demands on UNICEF remain high.

With the support of UNICEF and partners, a number of countries have made substantial advances in the prevention, care and treatment of HIV among children. Mother-to-child transmission rates have declined rapidly through high coverage of ARV-based interventions for pregnant women, mothers and their exposed children. Progress has been uneven, however, and many countries and marginalized groups still lack access to services and PMTCT and paediatric treatment coverage remains low. The expectation is that UNICEF will intensify its support in these areas to address major programme gaps.

UNICEF has also struggled to address the second decade of life, as evidenced by high risk of HIV infection among adolescent girls and young women aged 15–24 years. The organization has not actively promoted the second prong of the PMTCT framework regarding sexual and reproductive health services for young women living with HIV. As a result, children continue to face exposure to HIV at high levels and the risk of the epidemic rebounding among children is real. While of course UNICEF cannot cover all bases, as the de facto United Nations country lead for HIV and children, the organization must advocate for and facilitate a strategic approach that is truly comprehensive and sustainable over the longer term.
EXPAND UNICEF’s advocacy efforts to keep HIV prevention, care and treatment among children high on the global agenda.

TAILORED HIV programming carefully to country needs, capitalizing on UNICEF’s decentralized mode of operations and its focus on making a difference at the country level.

DEVELOP STRATEGIC approaches to keep HIV visible as a key corporate priority within UNICEF, across diverse organizational structures.

Clearly define UNICEF’s unique role and contribution to the HIV response in the post-2015 era, building on its comparative advantages.

TAKE THE LEAD on the mainstreaming agenda, demonstrating how HIV can be effectively linked with work in other key programmes and sectors.

Clearly position UNICEF’s work within existing partnership frameworks, which may need to be renegotiated or strengthened as required.

CONSIDER MAKING EQUITY the focus of continued programme scale-up, while strengthening UNICEF’s programming approaches to more explicitly address gender and human rights.

INVEST EFFORT in ensuring that the necessary funds for UNICEF’s HIV response are mobilized.
The following recommendations will feed into the development of UNICEF’s Strategic Plan 2018–2021. UNICEF’s role should be defined in the context of the 2030 Agenda for Sustainable Development, the agreement of Member States to Fast-Track\(^\text{18}\) the response over the next five years and the new global targets and commitments: to ensure that 1.6 million children living with HIV access treatment by 2018 as part of the 90-90-90 treatment target and to eliminate new HIV infections among children by reducing new infections in every region by 95 per cent by 2020.\(^\text{19}\)

**Recommendation 1:** Expand UNICEF’s advocacy efforts to keep HIV prevention, care and treatment among children high on the global agenda.

**ACTION POINTS:**
- Use UNICEF’s position and mandate and existing advocacy platforms – such as the Secretary General’s Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 and the new Start Free, Stay Free, AIDS Free initiative led by UNAIDS and PEPFAR – to strongly advocate for addressing HIV among children within the sustainable development agenda.
- At the global and regional levels, conduct focused political advocacy that engages the organization’s high-level representatives to effectively mobilize decision-makers, shift policies and raise funds for reaching global commitments.
- Use UNICEF’s capacity to develop and advance clear evidence about HIV among children of all ages and the associated impacts on child and adolescent growth, development and survival.
- Develop a communications strategy and related materials to increase momentum to address unfinished business related to HIV and children and raise UNICEF’s visibility as a key player in the international development architecture.

**Recommendation 2:** Clearly define UNICEF’s unique role and contribution to the HIV response in the post-2015 era, building on its comparative advantages.

**ACTION POINTS:**
- Define the organization’s role and focus in line with its mandate, recognized leadership, strong country presence, privileged access to government, civil society and development partners, trusted technical expertise and cross-sectoral experience.
- With strong leadership involvement at all levels, contribute to topical policy issues such as: clarifying the importance of integrating HIV within broader child health and development perspectives; planning for greater domestic contributions to programme budgets; and facilitating the inclusion of benefits for HIV-affected children in emerging national health insurance and social protection schemes.
- In light of constrained resources, increase attention on upstream policy efforts and seek to reduce the organization’s responsibilities related to implementation and technical support.


\(^\text{19}\) The 2016 Political Declaration on HIV and AIDS also includes regional targets.
Recommendation 3: Tailor HIV programming carefully to country needs, capitalizing on UNICEF’s decentralized mode of operations and its focus on making a difference at the country level.

**ACTION POINTS:**
- Focus the organization’s country level engagement on advancing the HIV and children agenda towards the new targets, especially in countries with continued high HIV incidence and prevalence among young women and children.
- Tailor specific HIV support to country needs, while increasing attention on upstream policy issues.
- At the country level, leverage UNICEF’s presence to ensure that the needs of children affected by HIV and their families are fully considered in the development of key policies and strategies, across all sectors.

Recommendation 4: Take the lead on the mainstreaming agenda, demonstrating how HIV can be effectively linked with work in other key programmes and sectors.

**ACTION POINTS:**
- Leverage linkages across HIV, health and nutrition, building on the A Promise Renewed initiative, to generate ‘Double Dividends’ for HIV and other results.
- Externally, break down prevalent vertical approaches to planning and budgeting, foster policy dialogue across sectors and encourage linked approaches to service delivery.
- Forge stronger bridges between efforts on the first decade of life and those on the second decade.

Recommendation 5: Develop strategic approaches to keep HIV visible as a key corporate priority within UNICEF, across diverse organizational structures.

**ACTION POINTS:**
- Preserve capacity for critical HIV-specific actions while effectively mainstreaming HIV across different sectors.
- Internally, intensify UNICEF’s collaboration, joint planning and shared targets across programmes and sectors at all levels.
- Ensure key staff competencies across sectors to plan and manage the delivery of expected HIV results and have leadership promote, facilitate and track changes.
- Ensure that all concerned staff have the guidance and support they need to strengthen such joint planning, budgeting and accountability processes.
Recommendation 6: Consider making equity the focus of continued programme scale-up, while strengthening UNICEF’s programming approaches to more explicitly address gender and human rights.

**ACTION POINTS:**
- Leverage the UNICEF equity focus to keep children on the HIV/AIDS agenda, including closing the treatment gap between adults and children and intensifying efforts in countries and groups with little progress.
- Ensure that equity is at the centre of UNICEF’s HIV and children response to guide programming in low-, middle- and even high-income countries.
- Increase attention to reaching underserved populations (i.e. leaving no one behind)
- Advocate for greater consideration of broader human rights and gender issues that remain at the core of adolescent vulnerability.

Recommendation 7: Clearly position UNICEF’s work within existing partnership frameworks, which may need to be renegotiated or strengthened as required.

**ACTION POINTS:**
- Working with United Nations system agencies, define a new division of labour and negotiate new ways of working to address recent shifts in global priorities that have affected all United Nations agencies.
- Strategically position the UNICEF HIV/AIDS Section within the crowded institutional environment by clarifying the organization’s niche, building strategic alliances with other partners, reducing transaction costs and avoiding duplication.
- Nurture existing partnerships, particularly with the Global Fund and PEPFAR, both at the leadership and technical levels.
- Seek a more formal partnership with PEPFAR, with an eye to harmonizing strategies and policies and facilitating action at the country level.
- Explore new partnerships, particularly with community-based organizations, to keep UNICEF positioned at the cutting edge of innovation and learning in the field.

Recommendation 8: Invest effort in ensuring that the necessary funds for UNICEF’s HIV response are mobilized.

**ACTION POINTS:**
- At all levels, intensify efforts to increase and diversify the resource base for UNICEF’s work on HIV/AIDS, including by increasing attention to non-traditional donors.
- At the country level, explore new funding sources, including from the private sector.
- Building on resource mobilization lessons learned, develop specific guidance with case studies to encourage and orient country level staff.
- Use available resources as strategically and efficiently as possible to more fully explore new roles, spend less on implementation support and other areas where other partners are present and invest more in developing policy options and innovative programme solutions.
See the full report on:
https://www.unicef.org/evaldatabase/index_95015.html

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